CLINICAL UPDATE

2nd December 2022

Middle East Respiratory Syndrome coronavirus (MERS-CoV)- risks associated with travel to Qatar FIFA World Cup

Background

The FIFA World Cup is taking place in Qatar from 20 November to 18 December 2022.

Clinicians are reminded that travellers to the World Cup are exposed both to infections endemic to Qatar, and infections associated with mass gatherings. They should discuss appropriate tests with their local infection services if required.

Clinicians and public health teams should specifically be alert to the possibility of Middle Eastern Respiratory Syndrome (MERS) in returning travellers from the World Cup and must follow the current MERS guidance concerning who should be tested and how to manage possible cases appropriately and safely.

MERS-CoV can be acquired from close contact with camels or from consuming camel products e.g., unpasteurised camel milk. Cases of MERS have been reported in humans in Qatar, including two cases in 2022, both with exposure to camels. However, there have been examples internationally of person-to-person transmission, particularly from nosocomial transmission in healthcare settings, most notably in a large MERS outbreak in the Republic of Korea.

Case definitions

The presentation of unconfirmed MERS-CoV that draws a high suspicion falls into 3 definitions and is as follows;

Case 1-

Any person with severe acute respiratory infection requiring admission to hospital with symptoms of fever (greater than or equal to 38ºC) or history of fever, and cough plus evidence of pulmonary parenchymal disease (for example, clinical or radiological evidence of pneumonia or acute respiratory distress syndrome (ARDS)

And at least one of the following:

- history of travel to, or residence in an area where infection with Middle East respiratory syndrome coronavirus (MERS-CoV) could have been acquired in the 14 days before symptom onset

- close contact during the 14 days before onset of illness with a symptomatic confirmed case of MERS-CoV infection
- person is a healthcare worker based in ICU caring for patients with severe acute respiratory infection, regardless of travel or PPE use
- part of a cluster of 2 or more epidemiologically linked cases within a 2-week period requiring ICU admission, regardless of history of travel

Note: Clinicians should additionally be alert to the possibility of atypical presentations in patients who are immunocompromised, atypical presentations may include absence of fever.

Case 2-

Acute influenza-like-illness symptoms (ILI) plus either of the following in the 14 days prior to onset:

(A) In Bahrain, Jordan, Iraq, Iran, Kingdom of Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates, Yemen: contact with camels, camel environments or consumption of camel products (for example, raw camel milk, camel urine) or contact with a hospital

Or

(B) In Kenya: very close occupational exposure (for example, in animal husbandry or abattoirs) to camels or consumption of camel products (for example, raw camel milk, camel urine)

ILI is defined as sudden onset of respiratory infection with measured fever of greater than or equal to 38°C and cough.

Case 3-

Acute respiratory illness (ARI) plus contact with a confirmed case of MERS-CoV in the 14 days prior to onset.

ARI is defined as sudden onset of respiratory infection with at least one of: shortness of breath, cough or sore throat.

IPC precautions

The following guidance is not exhaustive, and it is assumed that all other standard IPC practices such as hand hygiene etc are known and followed.

MERS-CoV is considered an airborne high consequence infectious disease. Notify receiving units if you are conveying a suspected case so that isolation facilities and testing can be arranged.

Personal protective equipment

- FFP3 (staff member must be fit tested for device), or a powered respirator unit and hood
- Eye protection (full face visor should be used if using valved FFP3)
- Hooded coverall with head covered
- Double gloves
- Fluid repellent boot covers

Vehicle decontamination

A full decontamination clean should be conducted as per the Trust vehicle decontamination manual.

This includes all vehicle-based equipment and vehicle compartment surfaces being cleaned using detergent followed by disinfection using a 1,000m ppm solution of chlorine. Please refer to manual for more detailed descriptions.

The PPE listed above must also be used for decontamination and the vehicle must be aired prior to cleaning and well-ventilated during cleaning and disinfection.

All waste generated throughout this care episode and decontamination should be disposed of as category A clinical waste (yellow bag in yellow container), separated from other waste types. Estates must be notified that a category A waste collection is required.

Conveyance of confirmed cases

Any confirmed cases of MERS-CoV that require transportation should be directed to HART for a High Consequence Infectious Disease transfer as part of standard process. However, if a clinician attends a patient where MERS-CoV is suspected then ensure AOC are notified and that HCID PPE is used during patient care and decontamination.

Useful links

MERS-CoV IPC guidance (publishing.service.gov.uk)

Algorithm for the investigation and management of possible cases of MERS-CoV (accessible text version) - GOV.UK (www.gov.uk)